IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

OREGON ADVOCACY CENTER, METROPOLITAN PUBLIC DEFENDERS INCORPORATED, and A.J. MADISON, Plaintiffs, v. PATRICK ALLEN, in his official capacity as head of the Oregon Health Authority, and DOLORES MATTEUCCI in her official capacity as Superintendent of the Oregon State Hospital, Defendants.	Case No. 3:02-cv-00339-MO June 11, 2019 Portland, Oregon

Oral Argument

TRANSCRIPT OF PROCEEDINGS

BEFORE THE HONORABLE MICHAEL W. MOSMAN

UNITED STATES DISTRICT COURT CHIEF JUDGE

APPEARANCES

FOR PLAINTIFF OREGON ADVOCACY CENTER:
Ms. Emily Cooper
Mr. Thomas Stenson
Ms. Kathy Wilde
Ms. Sarah Radcliffe
Disability Rights Oregon
511 S.W. 10th Avenue, Suite 200
Portland, OR 97205

FOR PLAINTIFF METROPOLITAN PUBLIC DEFENDERS:
Mr. Jesse Merrithew
Levi Merrithew Horst PC
610 S.W. Alder Street, Suite 415
Portland, OR 97205

FOR THE DEFENDANTS:
Ms. Carla Scott
Ms. Renee Stineman
Oregon Department of Justice
100 S.W. Market Street
Portland, OR 97201

Mr. Craig M. Johnson
Oregon Department of Justice
1162 Court Street NE
Salem, OR 97301

ALSO PRESENT:
Mr. Carl Macpherson

COURT REPORTER:
Bonita J. Shumway, CSR, RMR, CRR
United States District Courthouse
1000 S.W. Third Ave., Room 301
Portland, OR 97204
(503) 326-8188

I N D E X

(June 11, 2019)

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(P R O C E E D I N G S)

(June 11, 2019; 9:06 a.m.)

THE CLERK: Your Honor, this is the time and place set for oral argument in Case No. 3:02-cv-339-MO, Oregon Advocacy Center, et al. v. Mink, et al.

Counsel, can you introduce yourself for the record.

MR. MERRITHEW: Good morning, Your Honor. Jesse Merrithew representing plaintiff MPD. I'm here with the executive director from MPD, Carl Macpherson.

MS. COOPER: Good morning. I'm Emily Cooper, the legal director for Disability Rights Oregon and counsel for the plaintiff.

MR. STENSON: Good morning, Your Honor. Tom Stenson, Disability Rights Oregon, representing the plaintiff Disability Rights Oregon.

MS. WILDE: Kathleen Wilde, former legal director of Disability Rights Oregon, representing the plaintiff.

MS. RADCLIFFE: Sarah Radcliffe, also of Disability Rights Oregon, representing the plaintiff.

MS. STINEMAN: Renee Stineman with DOJ, representing defendants Director Allen and Superintendent Matteucci.

MR. JOHNSON: Craig Johnson for the Department of Justice, representing Director Allen and Superintendent Matteucci.

MS. SCOTT: Carla Scott for the Department of

Justice, representing defendants.

THE COURT: Thank you all for being here and for the materials that you've provided.

I think the principal burden of moving forward to a decision on the matter starts with DOJ, since the past and ongoing violations are apparently accepted as a given at this point. So it becomes a question what to do with that.

I'll start with your presentation.

MS. STINEMAN: Thank you, Your Honor.

A couple of housekeeping tools first off. The parties have filed a stipulation yesterday, Exhibit -- Docket No. 124, I believe, and that covers a number of the anticipated facts.

In addition to that, the State intends to bring two witnesses to testify today. Our witnesses will prove to you, Your Honor, that the State should not be held in contempt because they -- the State has taken all reasonable steps.

And we will start with Director Allen. He will explain the steps that have been taken and the plan for the future, and then that will be followed up by the behavioral health director -- also Director Allen -- and he will talk about his professional opinions.

THE COURT: Thank you.

Go ahead.

MS. STINEMAN: Oh, and another thing, Your Honor.

We've split our time so that we -- the State has 90 minutes and the plaintiffs have 60 minutes, and we plan on taking about 60 minutes with our examination, and reserving about 30 minutes for any redirect or closing.

THE COURT: Well, I'm glad you split your time that way. We'll see -- I mean, I reserve the right to hurry things along as I see fit, so --

MS. STINEMAN: Thank you, Your Honor. We'll call Director Allen, please.

THE CLERK: Please raise your right hand.

PATRICK ALLEN

called as a witness in behalf of the Defendants, being first duly sworn, is examined and testifies as follows:

THE CLERK: Please have a seat.

For the record, could you please state your full name and spell it.

THE WITNESS: Patrick Allen. P-a-t-r-i-c-k, A-l-l-e-n.

THE COURT: Go ahead.

DIRECT EXAMINATION

BY MS. STINEMAN:

Q. Director Allen, would you tell the Court what your

position is.
A. I'm the director of the Oregon Health Authority.
Q. And I'm going to -- do you have a witness binder with you?
A. I do.
MS. STINEMAN: And, Your Honor, the witness has a binder that's identical to the binder we've provided you.
BY MS. STINEMAN: (continuing)
Q. Would you turn to Exhibit 113, please.
A. Yes.
Q. And would you identify that document?
A. That's my current resume.
MS. STINEMAN: Oh, and Your Honor, the other thing is that the parties beforehand reviewed these exhibits, and I understand that the plaintiffs stipulate to the admissibility of the exhibits, so we will forgo any foundational questions.
THE COURT: That's right?
MS. COOPER: That's correct, Your Honor.
THE COURT: Go ahead, then.
MS. STINEMAN: Thank you, Your Honor.
BY MS. STINEMAN: (continuing)
Q. And Director Allen, what is your role as it relates to the Oregon State Hospital?
A. As the director of the Oregon Health Authority, and as the governing authority for the state hospital, I'm ultimately accountable for operations, decision making, and policy

decisions with respect to the hospital.
Q. And do you -- have you heard the term "the Mink order"?
A. I have.
Q. And what is your understanding of the Mink order?
A. My understanding of the Mink order is that when a court orders someone to the state hospital to be restored to competency for trial, we have seven days to accomplish that mission.
Q. And what is your responsibility specifically as it relates to the Mink order?
A. As the director of the agency and as the governing authority for the hospital, my accountability is to make sure that the policies, procedures, and systems are in place to accomplish that.
Q. And Disability Rights Oregon is one of the plaintiffs in this case, and I'll refer to them as DRO.

What is your understanding of DRO's role as it relates to the Mink order?
A. Disability Rights Oregon is a patient advocacy and intervenor organization for people with mental illness that gives them a federally recognized role to work with us and to have a special status to help oversee enforcement of the Mink order. From a practical standpoint, they're really our partner day in and day out as we work to manage all of our behavioral health programs, but especially as consulting with us on our

compliance with the Mink order.
Q. And what has the State's history been in terms of compliance with the Mink order?
A. Generally we've been in compliance with the order over the past 16 years or so. We have been in compliance in -- with the exception of a brief period in 2015, almost entirely, with the exception of circumstances where factors beyond our control, typically a court failing to send us on order or a jail failing to transport somebody, we've admitted people within seven days.
Q. And during that time has there been an increase in demand for restorative services?
A. Yes. Going back to 2012, we had a population of people in the hospital on aid and assist orders of a little over 100 individuals. Today that population stands at about 264, I believe, with an additional waiting list of about 40 more individuals.
Q. Historically, how has the State met that increase in demand?
A. We've gradually dedicated more and more of the hospital's overall capacity to serving the aid and assist populations. The hospital is organized in units or wards, if you will, of approximately 25 people per unit, and over time we have converted units from serving other populations that we served to serving the aid and assist population, the last conversion being as recently as October, when we experienced a significant

spike in enrollment and when our current period of failing to comply with the order began.

Q. And at some point I think you just mentioned that there was a spike in demand, and what did the State do in response to that increase?

A. Well, a couple of things. Well prior to the spike in demand, we had, in anticipation of continued increases in demand, begun developing legislative and budget proposals. Those are under consideration by the legislature today, but the development process began about 18 months ago.

In a more immediate response to the specific spike in October, in addition to allocating another unit of the hospital to the aid and assist population, we went to the legislative emergency board to ask for the authority and the resources to open a vacant unit at the Junction City campus of the Oregon State Hospital to accommodate yet more patients.

Q. I'm going to now ask you to turn to the witness binder, where you'll find some PowerPoint slides that are printed off.

MS. STINEMAN: Your Honor, you have copies in your binder as well, and the plaintiffs' counsel have them as well.

BY MS. STINEMAN: (continuing)

Q. You've described how in the fall of 2018, the increase in demand was something that the state hospital couldn't address by redesignating beds or units. When that became a reality, what did the State do to sort of assess the situation?

A. In considering the challenge at the state hospital, I find a couple of analogies really useful. The first is to think of the supply -- capacity of beds to treat people under aid and assist orders as something of a basin, and the basin has a faucet and a drain. And demand for the hospital really represents patients flowing in through the faucet, and the drain is the ability to return people to the community either for community-based restoration or back to jail to stand trial.

To address this, if you will, plumbing problem, we have sort of a three-legged stool of adding capacity to the hospital, trying to reduce the demand through policy and educational elements, and then trying to open up the drain through increased investment in community-based restoration.

Q. I'm going to ask you to turn to Exhibit 1, please.

MR. STENSON: And that would be the exhibit to -- Exhibit 1 to Exhibit 100. It's attached to his declaration.

BY MS. STINEMAN: (continuing)

Q. Director Allen, can you explain to the Court what this document is?

A. Yes. This represents the increase in the aid and assist admissions.

MS. STINEMAN: So, Your Honor, Exhibit 100 is his declaration, and then at the -- sort of the bottom end of the exhibit, you'll have little tabs.

BY MS. STINEMAN: (continuing)
Q. Okay. Exhibit 1.
A. So Exhibit 1 represents the admissions under aid and assist orders over time. The variable line is each month's actual admissions. The blue line that's a straight line is the trend over time.
Q. And how does this relate to your bathtub analogy?
A. This represents the faucet. This is people coming into the hospital on admissions, and you can see that over the time since 2012, the faucet has been progressively opened more and more over time.
Q. And please turn to Exhibit 2.
A. Uh-huh.
Q. And what is this document?
A. This is the same data represented somewhat differently. This is each year's total admissions, with a range of a high and low for the months in that year, and the average over the year.

So to illustrate, in 2019, year to date at the far right-hand side of the column, the highest month to date so far has been 74 admissions, the lowest 51, and the average 62.8.

The thing I would point out is both the floor and the ceiling have been increasing over time, and in the most recent data, 2018 and 2019, we've seen record months of admissions to the hospital.

Q. And that correlates to the time when you were no longer to address the increase in demand?
A. Right. That correlates to the time that we made our final conversion of a unit, and also like I mentioned earlier, changed some of our practices to do more intermixing of different kinds of commitment types for patients within the hospital.
Q. And could you turn to Exhibit 6, please.
A. Yes.
Q. And what is that document?
A. Exhibit 6 represents people who are eligible for return to their community for community-based restoration. Restoration is stabilizing someone's psychiatric condition, getting them to a place where they're able to meaningfully aid and assist in their defense.
Q. Let me take a step back.
A. Sure.
Q. Are these patients -- they're in the state hospital?
A. They are in the state hospital today.

Much of that restoration can be accomplished at the community level, either by not sending people to the hospital to begin with, or in these cases, returning them to the community for community-based restoration.

This is the current, I believe, list of individuals who are eligible for community-based restoration but have not

been ordered returned to the community by a court.

On the left-hand side you can see the county. There's some internal management data. The names have been redacted for privacy purposes. The important column is the column on the right that shows the length of time they have been awaiting a local court order to be returned to the community.

Q. And how does this relate to your basin analogy?

A. Oh, this is the drain. These are people who, if they were returned to their community, would free up space in the basin that would allow people from wherever they are in the county to be admitted to the hospital on an aid and assist order.

Q. And I want to go back to your three-legged stool approach and ask you -- maybe it's obvious. How does the first leg of the stool, which is increasing capacity, help address the rate at which admissions are happening?

A. Sure. I guess I would say that increasing capacity is the one thing amongst the legs of the stool in any strategy that we most directly control. If we add beds, those beds are immediately available at the point that they're added to be able to admit people from the waiting list.

The other legs of the stool around community investments and policy and education necessarily involve some kind of action by others, and so they can be important actions, and we can work hard to influence them, but we don't have

direct control over them the same way we would around capacity.
Q. And how does the second leg of the stool relate to improving rate of admissions, the policy and education leg?
A. A variety of ways, and it ranges everywhere from steps that we've taken at the hospital to create an expedited admissions policy that allows jails to contact the hospital's chief medical officer with respect to individuals who are extremely acute and in particular risk of harm to themselves and others, and ask them effectively to jump the line on the approval of the chief medical officer. It can be educational issues around, as we frequently do, holding a local forum to interact with jail and court staff around timely processing of orders and making sure that we get the orders so that we know about them, or working to change transportation schedules with the county sheriffs to assure that people are transported timely.
Q. And how does the third stool, increase community resources, help in addressing the rate of admissions?
A. Yes. So the community investments really focus -- have an impact both at the level of the faucet and at the level of the drain. The more community-based restoration resources there are, other community mental health investments, the more we could begin to turn down the faucet by having more people treated locally rather than referred to the state hospital if they don't require a hospital level of care, and the more

quickly we can return people to their community for restoration, the more spaces we can open in the hospital and reduce the average length of stay for people on aid and assist orders, which has been increasing over time.

Q. When you're making specific decisions relating to that strategy, can you describe to the Court what the context is and what -- sort of the framework you're working within. Are you making those decisions in a vacuum?

A. No. When we made those decisions, of course, we work internally to identify ideas, options, courses of action that we can take. But being a public agency, we then operate in the public sphere, and so we interact with a wide variety of stakeholders. Disability Rights Oregon, of course, is a significant one, both within its role as a PAIMI, as well as a general stakeholder of the organization from a behavioral health standpoint.

And then we need to take whatever course of actions we identify, investments, policy changes, those kinds of things to a variety of oversight bodies, the hospital advisory committee, the legislature, the governor's office, and local governments.

Q. And you mentioned PAIMI. Can you describe to the Court what that is?

A. Yeah. That's a federal designation. I hope I'll get this right. Patient Advocacy -- Advocate and Intervenor for People

with Mental Illness. It's a federal designation that gives Disability Rights Oregon a particular role to participate and intervene in matters such as this, in my lay understanding of that.

Q. Okay. I'm going to have you turn to the second of the slides, which is titled "Decreased Demands"?

A. Uh-huh.

Q. Do you see that?

A. I do.

Q. I'm going to have you use that walk the Court through the different steps that the State has taken in regard to addressing rates of admissions.

A. Sure. So in each of these three slides, we've tried to break the information down into some kind of digestible bits. Across the top is the notion of items that have been completed, things we have done, and that work is over.

In the middle column, "Work that's Ongoing," something that we've put in place that we do on a continuous basis and is currently happening.

And then "In Progress" are things that are in the midst of implementation being started, requests that have been made and are in the legislative process, those kinds of things.

This first slide talks about decreasing demand, how do we turn down the faucet and have fewer patients who don't need to be admitted to the hospital being admitted.

On the left-hand side, in the "Completed" column, the first cell is the expedited admissions procedure that I talked about, where a jail commander can call our chief medical officer and exchange health records and document someone's acute psychiatric condition, and we can make a decision about admitting somebody ahead of where they would be from a date order standpoint.

Second cell you'll see repeated in the remaining slides, and it is the notion that we reorganize the agency to do a better focus on behavioral health, and have recently hired a national expert in behavioral health, with a particular focus in the interaction of behavioral health with criminal justice involvement to help direct policy overall within the agency in these areas in particular, and I think you're going to hear later from him -- later from him today.

Q. And how about the ongoing efforts?

A. In the "Ongoing" category -- and these are -- we also call it the legs of the stool, so policy leg, the community investment leg, and the capacity leg, which isn't represented here, from a community standpoint, this resource connections is the regular and ongoing work that we do, county by county and court by court, meeting with court staff, the local bar, local law enforcement, and in this case we call out particularly things like the timely receipt of orders.

Prior to the brief period in 2015, in our current

circumstance, a significant number of -- in fact, virtually all of the cases where we failed to meet the seven-day standard were fairly straightforward things like the court never sent us the order that the person had been ordered to the hospital, so we didn't know they were there waiting for admission. So we worked with courts to educate them about the best ways to get us that information.

Q. I'm going to stop you there. I'm going to ask you to turn to Exhibit 4.

THE COURT: Which number?

MS. STINEMAN: Exhibit 4.

BY MS. STINEMAN: (continuing)

Q. Director Allen, could you please describe to the Court what that document is.

A. There are two lines on Exhibit 4 that go back to January of 2018. The top line, which spans most of 2018 at 100 percent, represents the percentage of cases where we were aware of the order and there was not a transport issue and that we transported someone within seven days. And you can see that when we factor out those two instances, we're at 100 percent until this October spike that we've talked about and then the ongoing spike.

The lower line is what's the overall whole total percentage of times we've admitted within seven days when including those failures to transmit an order to us or a

decision by a local jail that a particular day isn't convenient for them to transport and they're going to do it some number of days -- some number of days later.

So you can see those decisions have a small but important impact on our overall compliance rate.

Q. And so this resource connections that you were talking about, how does that relate to this exhibit?

A. The idea is to work to shrink that gap, and again it's one of those things that I talked about where we don't have direct control over it, but we can try to influence it. And so our staff work regularly to try to -- as court personnel and attorneys turn over, make them aware of the importance of getting us these orders and the mechanisms they should use to do that, and their value in the system.

Q. Please continue to the next ongoing item.

A. That's a community investment category, and this represents the investment that we make in three categories of assistance to community mental health organizations. That's a phrase that is whoever delivers mental health services at the local level. Frequently that's a county but not always. Sometimes it's a private nonprofit.

In any case, those categories are jail diversion, aid and assist programs, and local crisis, the idea being are there investments that we can make or programs that can be delivered locally that help people in crisis not escalate to the point

that they interact with law enforcement.

If they do interact with law enforcement and jail diversion, get them diverted to mental health services rather than booked in and lodged in the jail and charged with a crime, or provide resources at the local level for local restoration rather than state-based restoration. In all these cases, the idea is to help people get the help they need locally rather than have them referred to the state hospital.

Q. And would you turn to Exhibit 102, please.

A. Yes.

Q. And what is Exhibit 102?

A. First page of Exhibit 102 shows the sum total over time, going back to 2005, of investments we've made in those categories. On the PowerPoint, you'll see reference to $29 million. That's the most recent biennium. This shows you $60 million of investment in those three categories over the period 2005 to 2019.

That tells me a couple of things. One is that we've made significant investments in these areas, but that they have also ramped up significantly in the most recent biennium or two.

THE COURT: I'm going to pause you there for just a moment. So I appreciate what you're saying, but if you go at this rate, my court reporter is going to keel over before --

THE WITNESS: I apologize.

THE COURT: So you need to slow down.

THE WITNESS: I will do that.

THE COURT: Will you do that?

THE WITNESS: I will do that.

THE COURT: Thank you.

THE WITNESS: The subsequent pages break the investments down by a category.

The next page is aid and assist. And it shows the investments by state biennium. And what I particularly point out is that we've talked a couple of times about the fact that in 2015 there was a spike in enrollments -- or in admissions to the hospital. And you can see that in the 2015 and 2017 biennia, the investments in aid and assist programs increased significantly in response to that spike in the ongoing increase in enrollment.

The same is true for mobile crises, which is the next couple of pages, and then also for jail diversion, which is the final page.

You can also see that over time these efforts have spread from being focused on a handful of focused counties to being statewide investments.

BY MS. STINEMAN: (continuing)

Q. Let me ask you this. The total amounts here that are shown by biennium, are those dollars that were available during that biennium?

A. Yes.
Q. And to have that money available during that biennium, for example, to have the increase in aid and assist orders for the biennium of 2015 to 2017 to go from $1 million in the biennium before to $5 million, that biennium, when did that planning have to take place to get that money available for the biennium of 2015 to 2017?
A. Yes. So any budget action by the legislature, the action that's going on today for the budget that will begin on July 1st at the agency level begins about 18 months before that, starting in the first part of year before the legislature meets. So in the 2015-17 investments, that developmental group would typically have started in about January of 2014.
Q. And so the increase, why the increase in 2015?
A. The increase was in anticipation and following the trends over time. If you recall, the exhibit where we showed the increasing -- increasing admissions to the hospital, we could see that trend line projecting forward, and those budget proposals were in response to that.
Q. And if you'd return to the decreasing demand slide and continue with the "In Progress" column.
A. Sure.
So from a policy standpoint, we're currently evaluating of the three categories of admissions to the hospital -- guilty except for insanity, civil commitments, and

aid and assist orders and some subcategories within those -- are there any basis legally we have to prioritize those admissions further than we already do.

We're also engaged with the Oregon Judicial Department in the beginning stages of organizing a judicial department summit that would involve courts and the agency and others to help from an educational and process standpoint and improve the processes that the courts follow.

A couple of examples: development of clear bench guides for how admissions -- orders to the hospital can work ideally to be able to move that process along most quickly.

Mostly important is making sure judges understand the difference between restoration services and mental health treatment. People who are guilty except for insanity and those who are civilly committed receive a full suite of mental health services at the hospital. Those ordered to the hospital on an aid and assist order do not. They receive restoration to stabilize their psychiatric condition and nominal legal skills training to allow them to understand how a courtroom works and who is in charge and the role of their attorney and the prosecutor and some of those basic kinds of things.

You frequently hear the phrase, "The only way I could get them the help they needed was to order them to the hospital," and that's a bit of a misconception. So helping courts understand that is important as well.

The next couple of items. Senate Bill 24 is a piece of legislation which again about 18 months ago we began crafting for consideration by the legislature today. It's got a number of features. A couple I'll talk about in the decreased demand have to do with restricting the ability of courts to refer certain kinds of low-level offenders to the state hospital when that's not an appropriate referral. So low-level misdemeanors, people being referred by municipal court. About 60 percent of our aid and assist admissions were homeless at the time of their arrest, and about 40 percent of the admissions to the hospital had been charged with misdemeanors. And so we think those are -- this is a tool that can help reduce that.

Then finally -- and I'll talk about this a little bit more in a little bit more detail in another section, but we have contracts with community mental health programs that will have performance elements, and working to improve those performance elements to have them be more quantifiable and more accountable to the actual impact that they have on the aid and assist system through the investments we make.

Q. If you'd now turn to the next slide, which is titled "Increased Capacity."

A. Uh-huh.

Q. And walk the Court through what the agency or the State is doing to increase capacity.

A. Yes. On the left-hand side, in terms of completed activities, we talked about the unit that we converted from being used for people civilly committed to being used for the aid and assist population. That resulted in an increase in capacity of 26 beds. Again, in context of population back in 2012, that was around 100 individuals, that increased our aid and assist capacity to I believe 236 individuals.

Not captured here but related to that, I also mention the fact that we began intermixing our patient populations further, so beyond our dedicated capacity for aid and assist patients, we're running at about 264 patients all together today.

Again, I make reference to the behavioral health national expert that we've hired as our behavioral health director.

In the ongoing category, I made reference, I believe earlier, to asking the legislature for authorization to open capacity at Junction City, which would have resulted in about 25 beds of new capacity to address the aid and assist population.

We ran into fairly significant opposition, including from Disability Rights Oregon, to opening that bed capacity. So alternatively, the legislature in January gave us about $1.5 million in money for us to spend on new community capacity, the ability to restore people to competency at the

local level.

We made three different investments. The first of those are ten beds in Multnomah County that are open and in use today in our housing and restoring people who would be either in the state hospital or on the waiting list otherwise.

The rest of that investment is at the top of the next column in progress. We have 16 beds in Lane County, eight of which should be coming online any moment, if they aren't already, which are by virtue of leasing to them a freestanding cottage at our Junction City campus that's not used by the state hospital but that they're using for eight beds of community restoration.

And then seven beds in Coos County that are a mix of rental assistance and some dedicated beds that are a little further away from coming online.

In progress, the next piece that we're in the midst of accomplishing has to do with active negotiations we're in right now with an entity called the Northwest Regional Reentry Center. This is a facility that historically has had a relationship with the U.S. Bureau of Prisons to house individuals who are in transition to or from the federal corrections system. We very recently have become aware of the fact that they are interested in providing capacity to us for again community-based restoration, either people who could be restored in a facility there, or returned to that facility from

the state hospital after they're stabilized.
Q. And is this a matter that you've discussed with DRO?
A. We have.
Q. And what is their position on this?
A. We've had a very brief conversation with them, and they've allowed -- they're not specifically familiar with this specific facility and are open to getting a better understanding of its nature and how it operates, but in general, and based on familiarity with what they believe to be similar facilities in other parts of the country, they reacted pretty negatively and thought that this was a correctional environment that was generally inappropriate for this population.
Q. I'm going to have you turn to Exhibit 104, and then I'm going to ask you to slow a little bit your pace and then tell me, do you agree -- do you share Disability Rights Oregon's concern about this facility?
A. I do not.
Q. And tell me why.
A. A couple of reasons. I've had the opportunity to tour the facility, meet with staff, as well as some individuals who are -- who stay there, and believe it to be an environment that is significantly better than jail or alternatively homelessness.

More importantly, I've had staff, including our behavioral health director and other program staff, do more

extensive site visiting and vetting at the facility, and they believe that it is suitable as a therapeutic environment -- not obviously in all cases, but in many cases that could help reduce demand at the state hospital for people who are much sicker.

Q. And are the photographs in Exhibit 104 photographs of that facility?

A. They are.

Q. And do they reflect what you observed when you visited the facility?

A. They do.

Q. And again, if this is a successful negotiation, how many beds does the State intend -- or expect to add in terms of capacity?

A. We're negotiating for 40 to 60 beds.

Q. And what type of services?

A. These would be residential services to provide stable housing to enable the wraparound of other restoration services, legal education, other mental health services to help restore people to competence.

Q. And if you continue on the slide to the next item.

A. Yes. In terms of capacity, there's a reference to 26 state hospital beds. I made reference earlier to a cottage at the Junction City campus. If you're not familiar, the Junction City campus is a hospital proper with three eight-bed cottages

that are outside the secure perimeter of the hospital facility but on the campus, and one of those facilities that we're leasing to Lane County.

Based again on some feedback from DRO, these two remaining cottages are currently licensed as residential treatment homes, and we're working to spin those up and be able to have them become available for people who -- this is a little bit complicated, but are in the Junction City campus on civil commitments and eligible for community-based treatment, move them out of the Junction City hospital, which would free up capacity in the hospital proper. We would move some civilly committed patients from the Salem campus to the Junction City campus in those beds, thereby ultimately, when you net it all out, freeing about 26 beds worth of further aid and assist capacity at the Salem campus.

Q. Please continue.

A. Yes. The next cell is a policy option package. That's a state budget term for besides our base budget, what additional money would we request for different efforts.

Again, the planning for that begins about a year and a half before now. We have a package for $8 million of community restoration. That money would continue some of the investments we talked about earlier in Lane, Coos, and Multnomah County, but then there would be a substantial portion available for further similar investments in other communities.

These are the investments that I talked about in terms of improved contract terms that -- in the current round. And with these and with our overall contracts, we would work to improve the accountability of community mental health programs for the delivery of actual relief to the aid and assist population through those investments.

The next cell makes reference to money that remains from the sale of the Dammasch State Hospital a number of years ago. There's a trust fund that is statutorily protected but earnings and 5 percent of the corpus can be spent on housing for the mentally ill.

And we're trying to -- we're exploring right now how creative we can be with the definition of housing, to see if we could make investments that would specifically help with this population, since again 60 percent of individuals on aid and assist orders were homeless at the time of their arrest, and can we interface those things to come up with a strategy that would enable us to spend that money.

And then the last piece is sort of a macro-level policy issue, but we have -- the Oregon Health Plan is delivered through organizations called coordinated care organizations. About 85 percent of the spending are through those CCOs. They're accountable for behavioral health investments, and the more -- we're negotiating right now the most recent round of those contracts and better integration and

delivery of behavioral health is a significant element of those negotiations, as well as enhanced accountability for delivery of those behavioral health values.

And so that's also something that at the wider community level can contribute to keeping people out of mental health crisis.

Q. If you could turn to the next slide, which is titled "Streamline Discharge."

A. Uh-huh.

Q. Explain to the Court what steps are being taken to essentially unclog the drain that you mentioned earlier.

A. Yes. On the "Completed" column, in addition to the expert behavioral health director, we've hired two forensic evaluators. These are people whose job is to assess individuals, among other things, for whether they are now able to aid and assist in their defense or are eligible for -- together with the treatment team, assess whether they're eligible for community restoration. So this would help move people back to -- back to their counties to stand trial or whatever the disposition is going to be.

In the "Ongoing" category, again we call out the resource connections or out orders -- orders and transport, as well as other discussions at the local level to help make them aware of resources that are available that would help create more community-based placements.

The next issue is something we call (6)(b) letters. (6)(b) is a subreference in the relevant Oregon state statute, and it has to do with the technical means by which someone who has been found ready for community restoration is returned to the community. The hospital issues a (6)(b) letter, which is sent to the court, and we then await a court order to discharge the person from the hospital to appropriate community-based treatment.

This is a significant problem area for us right now, because frequently either courts or attorneys disagree with the (6)(b) order or, as frequently, the order just simply lies unacted on, and so no action is taken, no order is entered, and thus the person stays at the hospital. That's the list of 24 people that we discussed from an earlier exhibit who are awaiting return to their community.

The last couple of things to call out in terms of in progress, we're evaluating a variety of legal questions in front of us, ranging from appealing the Washington County contempt decision, to examining, in the case of (6)(b) orders, is there a way that we can have standing to go into a local court and in some fashion force the court to consider the (6)(b), the (6)(b) letter and other issues.

And then the last piece, earlier I talked about Senate Bill 24, in terms of who can be referred to the hospital on what kind of charges. Here what we're trying to call out is

the notion of is there a way in Senate Bill 24 to create a different level of enforceability around (6)(b) orders.

If I could, there's one issue of Senate Bill 24 I neglected to call out earlier, and it has to do with the relationship of the court to the community mental health program. Senate Bill 24 would require the court to consult with the county health department to figure out do the mental health professionals in the county believe an individual can be treated locally, and that's a best practice that's used by some counties where the system functions well, but it's not required, and there are a number of counties that never even consult with their community mental health program. And so Senate Bill 24, as it's being considered right now, would require some degree of consultation in all cases.

Q. Now that you've outlined what the State has been doing and what the State has completed and what the State is planning on doing, I want to ask you to go back to DRO's role in this whole process --

A. Uh-huh.

Q. -- and ask you in the consultations that the State has had with DRO, have they mentioned any action the State should be taking that is not on this list?

A. We believe that we are doing everything that they have suggested, short of one item, which is unilaterally releasing individuals from the state hospital.

Q. And why are you not doing that?
A. I don't believe we have that legal authority.
Q. So as you sit here, Director Allen, does the State have a plan with a fixed timeline, in terms of coming into compliance with the Mink order?
A. Yeah. In addition to the items that you've seen on the spreadsheet, I think there's an exhibit which is a directive from me to staff which takes a variety of efforts that have been or currently are underway, consolidates it into a single place --
Q. Let me pause, then, and turn you to that exhibit if I could help here. Turn to Exhibit 105, please.
A. Uh-huh.
Q. And there are related documents at Exhibit 106, 107, 108, 109, and 110.

Please continue.

A. Yes. So Exhibit 106 is the directive to staff that consolidates this work into a single place and makes clear my expectations, timelines, and those kinds of things.

105 is basically a letter to the governor, outlining those for her, and then there is some details that follow.

The bottom line of all of this work is that yes, we have a comprehensive plan to address the relatively recent spike in admissions that I believe will get us back into compliance.

Q. And what's the timeline for that?
A. We will be back in compliance, absence a further spike in admissions, within 90 days.
Q. If you could turn to Exhibit 111.
A. Uh-huh.
Q. And if you could explain to the Court what this document is and how it relates to that plan.
A. Sure. Exhibit 111 is a forecast model from our staff at the state hospital. The dark line that runs variable from the left-hand side is the total aid and assist population in the hospital going back to January of 2014. The straight line that tracks along with that is the stated capacity, the size of the basin for aid and assist patients over that period of time.

The increase up to 369 beds would be the increase that would result from the change at Junction City, as well as basically having beds that we would control through Northwest Regional Reentry.

And then the four lines that kind of fan out from there are from conservative to relatively less conservative estimates of how long that capacity would last. And what that is showing you is that the most conservative estimate would show that capacity lasting through January of 2021, the least conservative through July of 2023, and so the bottom line of all of that is that staff forecast that the short-term steps would result in buying us two to four years of time for the

long-term investments we've made and have in process now to bear fruit.

Q. On this chart does it show when it's anticipated to be in compliance, the State is?

A. Yes. That shows us in compliance basically at the time we're able to bring those additional beds at Junction City and at Northwest Regional Reentry, and that's within about 90 days.

Q. And let me ask you a little bit harder question. Why should this Court trust that the State will be in compliance within 90 days?

A. Well, a couple of things. We've largely been in compliance for a long period of time, and we've demonstrated that we're willing to take steps all along the way to maintain our compliance until this most recent period of time. And even in this most recent period of time, we've on an ongoing basis been taking those steps.

Moreover, from -- and I think, you know, I think even in the current data, I think the McDearos (ph) filing says that at the time of the filing, they showed 76 people waiting for admission to the hospital, and today that admission list is 44 people, with I think 28 who have been waiting longer than seven days as of yesterday. I think that's a number that changes every day.

But, moreover, the professionals that work for me, our behavioral health director assure me that they believe

these actions are feasible because they focus on capacity. They're in our direct control, and based on my years of experience administering public programs, I'm confident that we can deliver that capacity.

MS. STINEMAN: Thank you. I have nothing further from this witness.

THE COURT: You may inquire.

THE WITNESS: I'm sorry. Before he starts, could I have some water?

THE CLERK: (Handing.)

MR. STENSON: Good morning, Your Honor.

CROSS-EXAMINATION

BY MR. STENSON:

Q. Good morning, Mr. Allen.

A. Good morning.

Q. The population of aid and assist patients at the state hospital has been rising steadily and steeply for more than six years, correct?

A. I would agree steadily, I would not agree steeply.

Q. OSH has admitted roughly 25 aid and assist patients to the hospital's population every year since 2013. Would you agree with that?

A. I would agree with that. I would say the curve steepened in the second half of 2018.

Q. And, in fact, OSH has reported to the Oregon legislature repeatedly over time that there was a very sharp rise in the population at the Oregon State Hospital, correct?
A. I believe that's correct.
Q. As I look through these -- this PowerPoint you've created, the slides you've created, there are very few dates on here. So, for instance, the -- some of the things even that you've completed, you've hired a behavioral health director, completed your expedited admissions procedure, and that's just in the last 12 months, correct?
A. That's correct.
Well, with respect to the expedited admissions procedure, I guess I would say that was formalizing a previously existing process and documenting it. That process existed prior to that.
Q. All right. So, in many senses, most of these things we could have asked for more funding for the -- the Health Authority could have asked for more funding for community-based placements prior to December 2018, for instance, correct?
A. Well, I think if you look at the exhibit that showed the investments in aid and assist investments, jail diversion, and crisis intervention, we were over an extended period of time asking for more resources over time.
Q. Okay. So when we look at that document, for instance, for jail diversion, you asked for $33 million over the period from

2005 to 2019. So over 14 years, a little over $2 million a year, correct?

A. I'm just getting to that exhibit right now.

I'm sorry, would you repeat your question?

Q. So your Exhibit 102 states that you invested $33 million in jail diversion from 2005 to 2019. That's roughly a little more than $2 million a year, correct?

A. That's correct.

Q. Okay. And the budget for the Oregon Health Authority per biennium is about $20 billion; is that right?

A. Including Medicaid, yes.

Q. And the budget for the state hospital is roughly 550, $560 million?

A. Sounds approximately correct, yes.

Q. And the cost of keeping somebody in the hospital for a day is about $1,200, correct?

A. Twelve, $1300, yes.

Q. And so with the Oregon State Hospital containing -- about one-third of its population is now aid and assist patients, correct?

A. No. It's over 40 percent today are aid and assist patients.

Q. Okay. So roughly 40 percent of the state hospital budget is going into treating people on site, and 40 percent of that 250 is more than $100 million, correct?

A. I don't know that I can answer that question because I don't know whether the spending per patient tracks differently across different commitment types.
Q. In -- earlier this year, OHA submitted an agency request for funding from the legislature for $7.8 million for community restoration for aid and assist clients, correct?
A. That's correct.
Q. And did you believe when that agency request was filed that if the legislature fully funded it, that you could admit all of your Mink detainees within seven days?
A. Yes.
Q. Okay.
A. Well, let me expand that answer, if I may. That in combination with Senate Bill 24 and Senate Bill 25 and the existing base of investments that we're making, as well as all the other activities that are not fund based, that whole package of things, yes.
Q. Your proposed solution which you presented today includes paying for hospital expansion -- expansion of hospital facilities, paying for space in the Northwest Reentry Center and in the community. How much would that plan cost in total?
A. The expansion of that capacity at Junction City would be about $6 million over the course of a biennium. We're still negotiating the cost related to Northwest Reentry. It would be significantly less.

Q. Significantly less?
A. Than $6 million, yes. Because it's not providing a hospital -- it's a residential treatment home level of care in a state agency environment.
Q. Has the money for that -- your proposed arrangements with the state hospital space with the Northwest Reentry Center, has that been appropriated yet?
A. We will be able to pay for that investment.
Q. Okay. You indicated you're still in negotiations. I take it that means that you haven't signed a contract?
A. That's correct.
Q. And so it's certainly possible that the contract will not go through, correct?
A. It's possible.
Q. It's possible that rolling out placements for 40 to 60 people at a new facility will take much longer than 90 days, correct?
A. Unlikely.
Q. Okay. In rolling out just the seven beds in Coos County, for instance, that money was appropriated in December and those beds are still not available, correct?
A. No. Those beds are available and currently unused and we're working to facilitate their use. And there are a mix of beds and rental vouchers, and so partly they're driven by access to available rental units in the market.

Q. And you said that the Lane County beds that were achieved through that December 2018 E-Board apportionment, those are just coming online now in June, correct?
A. Uh-huh.
Q. Now, the Northwest Reentry Center is a former -- is a current federal halfway house, correct?
A. It's been characterized that way, yes.
Q. So it is exclusively for people who have been convicted of federal crimes, correct?
A. Or whose adjudication is pending, is my understanding.
Q. Okay. It is not a treatment facility, correct?
A. There are mental health services that are available there, but it's not a secure residential treatment facility, if that's what you're asking.
Q. Okay. All right. Have you had a chance to look at the behavior standards for the facility, their expectations for their clients?
A. I have briefly reviewed the residents guide, yes.
Q. Are you aware they have a no tolerance policy for disrespectful behavior?
A. I'm not familiar with the document in detail. This is part of what I've asked our expert staff to review.
Q. Would you say that a facility that has a no tolerance policy for disrespectful behavior is an appropriate one to send people who are seriously mentally ill, to the degree they are

unable to aid and assist their attorneys?
A. Well, first, I don't know that I have enough knowledge of exactly what that means to be able to answer the question. Secondly, that, I think, assumes that we wouldn't be able to negotiate any changes to that based on this particular population. So I don't think I can answer that.
Q. So if -- assuming that that were the policy there, not only would you have to negotiate a price for those services in the next 90 days, but you'd also have to renegotiate exactly the terms and standards for holding aid and assist patients there, correct?
A. No, that's not what I said. What I said is I don't know in detail what the line that you quoted out of context from the policy guide really means, and if it means what you say it means, then we've not explored whether there could be changes in that. I think that's a -- there's a lot of hypothetical built into that.
Q. There are indeed a lot of hypotheticals in getting this online in 90 days.
MS. STINEMAN: Objection, Your Honor.
BY MR. STENSON: (continuing)
Q. In the initial 2017 budget for the Health Authority, the legislature gave you $5.8 million to spend on community restoration, correct?
A. I would have to consult documents to know for sure, but

that sounds approximately correct.
Q. And then on top of that you get another $1.5 million for restoration services, correct, from the E-Board?
A. Correct, yes.
Q. So cumulatively for 2017 to 2019, you got $7.3 million, correct?
A. Yes.
Q. And then you asked for $7.8 million for restoration services in your most recent budget request?
A. Correct.
Q. For those aid and assist restoration services?
A. Community-based restoration, yes.
Q. So even at the time when the agency was in violation of a federal court order and dozens of people were staying in jail cells who should be in the hospital, the Health Authority believed that an extra $500,000 would fix whatever further problems there were, correct?
A. I'm not following your math.
Q. $7.3 million from 2017 to 2019, $7.8 million for 2019 to 2021.
A. Oh, no, I think you misunderstand the budget documents. The $7.8 million, I refer to it as a POP, a policy option package. That presupposes the existing level of spending and then is an incremental addition above that. So the right way to think of that is not the difference, it's additives. So

we've proposed more than doubling that spending, and we began that proposal about 18 months ago, in anticipation of being in the challenge that we were now, although not as great as it turned out to be.

Q. The expectation that is imposed on counties in exchange for the community placement money is that each county will reduce their hospital aid and assist budget usage -- excuse me, bed usage by 10 percent, correct?

A. For the $1.5 million increment from the E-Board, that's correct.

Q. So for Lane County, that means about four beds in any given month, correct?

A. I would have to look at a chart, but that sounds about right.

Q. One or two in the case of Coos County?

A. Probably.

Q. And about seven for Multnomah County?

A. (Nods head.)

Q. So even if all of those benchmarks had been achieved, that's cumulatively 12 or 13 beds in a system that's currently -- I think 44 people on the waiting list, correct?

A. Yes.

Q. On Friday, June 7th -- so four days ago -- you put out a memorandum to the governor and an order to your administrators regarding the aid and assist hospital -- cases at the hospital,

correct?
A. Yes.
Q. As part of your goals, you set forward several goals for your staff around using aid and assist numbers, with completion dates for July and August 2019, correct?
A. Yes.
Q. For instance, you ordered OHA staff to speed up the discharge process for patients who are not yet able to aid and assist but who no longer need hospital level of care?
A. Correct.
Q. What does that mean? How will they do that?
A. We've assembled basically a strike team across the health systems division in the state hospital and staff who are today working together to identify individual patients and connecting them with community-based resources and working to expedite completion of the (6)(b) process.

I saw a status update on this earlier today. It -- I won't try to quote from memory because I looked at it quickly, but there are individuals who have moved off that list as a result of that work.

Q. And you also said you wanted to explore other funding options for community restoration, including funds left from the decommissioning of Dammasch State Hospital?
A. Dammasch, yes.
Q. What funds do you think would be identified and how would

you use those funds?
A. If you look at the matrix on the page that is increased capacity in progress, this is the -- on the right-hand side, five cells down, it's $1.5 million. That's the amount that is available that is the 5 percent of corpus plus earnings that is statutorily eligible to be spent on housing for people with mental illness.
Q. That fund has existed since the closing of Dammasch State Hospital in 1995, correct?
A. I believe that's correct.
Q. So you're still asking your staff in June of 2019 to determine if further full-time forensic evaluator positions are needed, according to your letter, correct?
A. Yes.
Q. It seems like most of these steps outlined in your proposal here are reasonable steps, many of them which could have been taken a year, two years, three years ago, evaluating what the response of the State should be to (6)(b) orders, prioritizing admissions, looking at forensic evaluators. There's no -- there's nothing that would have legally prohibited you from taking steps like increasing funding, training people, evaluating your processes prior to June of 2019, correct?
A. Well, a year or two ago we were in a completely different circumstance than we are today, taking actions at that time,

developing proposals that are currently being considered by the legislature for funding and policy today, and remaining largely in compliance with the order. I can't think why I would have done something like ask about my ability to limit the access of the hospital to people who are civilly committed when I was complying with the Mink order.

Q. We've all seen and you've already stated that the rate at which people are being admitted on aid and assist has been growing steadily since 2013, and nothing that the hospital had done prior to that point had really derailed that progress, correct?

A. I think everything that the hospital did enabled us to largely remain in compliance with the order. What you're neglecting I think to see is that there was an increase in the rate of growth in the second half of 2018 that was, in fact, unanticipated and that we're working hard to respond to now.

Q. Okay. Let's take a look at that. So in Exhibit -- in your Exhibit 1 to your declaration, there is -- there are high numbers in around October 2008, but those are also -- there are similar spikes in 2016, correct?

A. Yes.

Q. So the peak number, the highest number of aid and assist admissions in 2018 was 72, the highest number in 2016 was 69.

A. I think Exhibit 2 is actually more useful for this discussion. If you look at Exhibit 2, there are a couple of

numbers that I think help drive this. It's the significant increase in the floor admissions from numbers that were historically in the 30s to 50 admissions as a minimum number of admissions, and the smaller but significant increase in the maximum admissions to record levels. You then see that the average per month is 20 percent higher in 2018, and so far in 2019 than the corresponding numbers in 2016 and '17, and dramatically higher than they were in 2012 through '14.

And so if you look -- again, if you look at those, if you look at it in those terms, you can see a relatively steady increase through 2017, and a very significant increase in 2018 and so far in '19.

Q. The average number of aid and assist admissions increases virtually every year from 2012 to 2019, correct?

A. Yes, but not at the rate of increase, and with the increase in the minimum number of admissions over that period of time. Prior to that, I think as in Exhibit 1, you see ups and downs. The downs go away and we end up at a much narrower band of admissions, which is driving not only the whole number of people being referred to the hospital, but also causing the average length -- as the population increases for aid and assist, causes the average length of stay to increase from about 70 days to about 80 days.

Q. You've indicated that there are dozens of aid and assist patients who no longer need a hospital level of care and are

ready to transition to a community setting for restoration, correct?
A. About 24, I believe, yes.
Q. Under Oregon Statute 161.370(6)(b), instructs the state hospital to inform the criminal court judge when an individual is no longer a danger to himself or others or when the individual can access restoration services in the community, correct?
A. That's correct.
Q. And when a judge receives such a letter, according to the statute, the judge "shall order the person released," correct?
A. That's my understanding.
Q. And sometimes state courts did not abide by their obligation to order the person released, correct?
A. Or they make a finding that's different than ours.
Q. Can you point me to anything in the records OHA has put forth for this Court showing that any hospital attorneys or Oregon DOJ attorneys have filed their own motions to release patients who no longer need to be in the hospital under (6)(b)?
A. I don't believe I can point you to documents that are in my exhibits.
Q. Can you point me to anything in the records that you provided that shows that any hospital attorneys or Oregon DOJ attorneys have appeared in court personally to argue for the release of patients under (6)(b)?

A. I'm not aware of such documents.
Q. Can you point me to anything in the records you provided that shows that any hospital or Oregon DOJ attorneys have filed a petition for a writ of mandamus or other appellate assistance to obtain the release of a patient detained under (6)(b)?
A. I cannot.
Q. Has anyone from OHA requested permission from this Court, the United States District Court, to release any patient who a state criminal judge refused to release?
A. I'm not aware that we have.

I would say we did consider coming to the Court to ask for a modification of the order itself, and were advised by the then executive director of DRO that DRO would oppose that.
Q. Okay. With regards to the 2018 Emergency Board money, an OHA publication states that, among other things, contracting requirements pose challenges to timeliness.

Has OHA taken any steps to obtain from this Court an order that would shorten the contracting process or allow OHA to access funds that were otherwise restricted by legislative limitations?
A. We have not.
Q. You're the chief officer of the Oregon Health Authority, and you have the most power, except perhaps for the governor, over the State's behavioral health program across the state; is that correct?

A. I run an agency that has significant budget and significant influence, yes.
Q. Okay. And you play a role at OHA in requesting funds from the legislature and can determine how appropriated money is spent on community-based mental health services and housing, correct?
A. Subject to legislative direction and statute, yes.
Q. Subject -- after substantial discussions with the United States Department of Justice in 2016 regarding the Department of Justice's concerns that OHA didn't provide adequate community-based mental health services, OHA finalized the Oregon Performance Plan, correct?
A. Yes.
MS. STINEMAN: Objection, Your Honor; relevance.
THE COURT: Your response?
MR. STENSON: The Oregon Performance Plan relates to the behavioral health services provided by the Health Authority, including discharges from the hospital. It goes to both -- it's a preparatory matter relating to introducing other evidence relating to how the hospital is handling patients and also goes to --
THE COURT: How it's generally handling all its patients?
MR. STENSON: Yes, Your Honor.
THE COURT: And that will be relevant how?

MR. STENSON: Well, crowding from any source, from any patient absorbs a bed in the hospital and it takes one away from somebody who is sitting in a jail cell.

THE COURT: All right. I'll allow you to attempt to show relevance.

MR. STENSON: Sure.

BY MR. STENSON: (continuing)

Q. As part of the Oregon Performance Plan, OHA promised to create -- promised to ensure that 85 percent of all civilly committed patients would be discharged within 25 days of hospital staff deciding they're ready to transition to a less restrictive setting, correct?

A. With respect to people with serious and persistent mental illness who are civilly committed. It's a narrow subset of our overall patient groups, yes.

Q. In fact, over its the second year, the hospital actually got worse at releasing those individuals promptly, declining from 53 percent in third quarter of 2017, to 48 percent in the second quarter of 2018, correct?

MS. STINEMAN: Objection, Your Honor. This --

THE COURT: What's your objection?

MS. STINEMAN: This is not relevant, and --

THE COURT: I've already heard that objection and overruled it.

BY MR. STENSON: (continuing)
Q. Is that correct, that the hospital got worse in its performance at releasing civilly committed patients?
A. The performance degraded somewhat, which had we improved would be helpful to the extent that we were able to convert more civil units to aid and assist units.
Q. OHA also set a goal in the Oregon Performance Plan that 90 percent of individuals civilly committed to the hospital be released in 120 days, correct?
A. I would need to refer to the agreement to know whether that's correct.

MR. STENSON: Your Honor, I have nothing further.

THE COURT: Thank you.

Any redirect?

MS. STINEMAN: Yes, Your Honor, just briefly.

MR. MERRITHEW: Your Honor, if I may, I had a couple follow-up questions on cross on behalf of MPD.

THE COURT: Go ahead.

CROSS-EXAMINATION

BY MR. MERRITHEW:
Q. Mr. Allen, could you refer to Exhibit 111 again, please.
A. Uh-huh.
Q. You testified that in 90 days, you believe your agency would be back in compliance with this Court's order; is that

correct?
A. I believe that's correct.
Q. On Exhibit 111, the graph demonstrates a flat line of admissions and then a bump when capacity increases. Do you see that?
A. That's correct.
Q. That's not actually likely to happen, is it?
A. Well, because we're at our capacity of about 264 patients, our admissions equal our discharges, so this is not admissions, this is total population. And so the total population would remain more or less at 264 patients, plus or minus one or two, based on daily activity, until we increase that capacity, if I'm following your question.
Q. So not represented on that chart are the folks who are sitting in jail and not getting a hospital bed; is that right?
A. The wait list is not reflected here, if that's what you're asking, though it has decreased since the time this action was filed.
Q. Do you have an estimate as to how many people -- as to how many people will be held longer than seven days in jails during the course of the next 90 days while you get these new beds online?
A. I do not.
Q. Would you concede that there will be people who will be held in jail, in violation of this Court's order, over the next

90 days while you get those new beds online?
A. I would.
Q. The projection of -- allowing that you get all the beds that you hoped to get from the Northwest Reentry Center and the colleges, still by your own projections could run out of capacity by January of 2021; is that correct?
A. By the most conservative projection, that's correct.
Q. And given that that capacity doesn't increase for 90 days, that would lead to the state hospital again being out of compliance only 15 months from the point at which it came back into compliance; is that right?
A. Yeah, that sounds mathematically correct, based on the calendar and based on the most conservative estimate.
Q. What's the plan after January of 2021?
A. The plan is actually before January of 2021, and that's this collection of items that we've talked about in terms of significant investments, policy changes, contracting changes, educational work policy changes and those kinds of things. The idea is to buy us short-term capacity to allow those longer-term efforts to bear fruit.
Q. Nothing the state hospital has done so far has slowed the rate of admissions from aid and assist populations; is that correct?
A. That's correct, because the state hospital doesn't have control over the rate of admissions to the hospital.

Q. Has the state hospital made efforts to slow the rate of admission?
A. We've made legislative proposals before that are similar to Senate Bill 24, and we've been engaging in educational and outreach -- outreach work, yes.
Q. And yet that increase in admissions has steadily gone up, correct?
A. That's not quite true. I think if you look at -- if you look -- Give me a moment.

If you look at Exhibit 4, Exhibit 4 is the one that shows the rate of compliance with the Mink order. Either with or without the missing orders and transport issues, you can actually see that in late 2018, we were able actually to positively influence our rate of compliance not just from a capacity standpoint but also from work that we were doing with local jurisdictions. I think that especially focused around orders and those kinds of things.

Q. Here's what I'm driving at.
A. Sure.
Q. What's the contingent plan? If the efforts you're making now don't slow the increase in demand for capacity, what's the hospital going to do in January of 2021 in order to remain in compliance with this Court's injunction?
A. I would again request resources and authorization to open as many as two units that are currently vacant at Junction

City.
Q. And how long would that take?
A. About six months to be able to -- the -- once we receive the authorization, it would take about six months, and that would be approximately 50 further beds worth of capacity.
MR. MERRITHEW: That's all the questions I have.
THE COURT: Go ahead with your redirect.
MS. STINEMAN: Thank you. Thank you, Your Honor.

REDIRECT EXAMINATION

BY MS. STINEMAN:
Q. Director Allen, if you would revisit the slides that we reviewed with the Court, and turn to the page entitled "Decreased Demands."
A. Yes.
Q. Isn't it true that each item on this page that you testified to extensively is intended to address the faucet or the demand on the services that you were just asked about?
A. That's correct.
Q. The beds at the state hospital, are they essentially one for one? So if you release a civil patient, can you necessarily put a 370 patient into that bed?
A. No, for a couple of reasons. There are certain kinds of beds that we designate for certain kinds of patients, and the best example are beds we call neuro/geri beds. These are

senior citizens who have got advanced dementia, traumatic brain injury, those kinds of things, who would be uniquely vulnerable to potentially being victimized by younger, more dangerous patients. So we don't mix those populations.

Secondly, when we bring in individuals on aid and assist orders, they frequently are more psychiatrically acute and require a higher level of care. So as we manage our bed population -- I'm trying to figure out a simple way to describe this. If we have 25 beds on a unit, we can typically put 24 people in that unit, keeping one bed available for movement of patients, as is standard hospital practice.

On an aid and assist unit that's acute, we may need to keep two beds or even three beds open for that kind of movement. And so there's not a one-to-one correlation.

MS. STINEMAN: Nothing further, Your Honor.

THE COURT: Thank you. We'll take a short break before any further testimony.

THE CLERK: Court is in recess.

(A recess is then taken.)

THE COURT: Please continue.

MS. STINEMAN: Your Honor, after rereviewing the evidence, and upon confirming that we've admitted Exhibits 100 through 113, in light of the time, we've opted not to call any further witnesses and are prepared to close.

THE COURT: Thank you.

MS. COOPER: Plaintiffs are also prepared to close.

The one thing I would note is plaintiffs split up our closing argument and reserve the last two minutes for our co-counsel from MPD.

THE COURT: Then whoever would like to go first may proceed.

MS. SCOTT: Thank you. Carla Scott for the defendants.

I'd like start by addressing just two legal arguments that plaintiffs made in their brief, responding to the brief we filed for this hearing.

Plaintiffs argue first that the State cannot mount an all reasonable effort defense if they're not in substantial compliance with the underlying order. I'd like to point out that that's not the case in the Ninth Circuit. For example, in *Kelly v. Wengler*, Ninth Circuit, 2016, in that case everyone agreed that the party was not -- was, in fact, in substantial violation of the underlying order. The Court nevertheless evaluated carefully the reasonable efforts defense.

Second, plaintiffs argue that we cannot relitigate defenses we raised in the original Mink case, and we're not doing that here. We're litigating our affirmative defenses to contempt. The two cases plaintiffs cite are document production cases where the defense was a privilege. They could not reassert that privilege in defense to contempt.

The matter before this Court is about only a single term, "court order," requiring the hospital to admit 370 patients to the hospital within seven days of court order. That's all this case is about here today.

The State acknowledges that it's not presently in compliance with that order, despite having taken and continuing to take all of the steps described in the exhibits and testimony before the Court.

As the evidence shows, the hospital and OHA are already taking many of the programmatic steps that plaintiffs seek, and the hospital has a clear plan to bring itself back into compliance by 90 days from today. Indeed, the steps that plaintiffs' own expert puts forth in the affidavit that they filed that OSH should take, the State has taken and is taking and is expanding on that, as the evidence shows before the Court.

In sum, the evidence of reasonable steps falls into three categories. We're increasing capacity at the hospital and in the community. We're taking significant steps to decrease demand and to streamline discharge. We are making investments in the community, investments in the hospital, and policy changes in the law and how the hospital is running its units.

Because the State has taken all reasonable steps yet is not presently able to comply, but is in a position to come

back into compliance within 90 days, a finding of contempt is not warranted. However, if the Court were to conclude otherwise, the State notes that plaintiffs' requested remedies would expand the court order at issue to a system-wide permanent injunction, including various programmatic steps designed to overhaul Oregon's entire mental health system. While plaintiffs' position is laudable and the State absolutely shares their goals, that's not the order before this Court to enforce. Sanctions for contempt should not be ones that do not come to an end when the contempt order comes into compliance.

As the cases cited in the State's brief make clear, in fashioning contempt remedies, federal courts should exercise the least possible power adequate to end the contempt. The more the remedy is directed toward a state or local government entity, federal courts also should give appropriate consideration to principles of federalism in determining the availability and scope of equitable relief. All but one of plaintiffs' requested relief -- fines -- would run afoul of these principles.

The programmatic requested sanctions are overbroad and are, in fact, not in addition -- they're the same as what the State is already doing, in essence, and they're not designed to achieve compliance with the injunction any sooner than the State is already on track to achieve, nor will the programmatic forms of requested relief end once the hospital is

back in compliance.

Therefore, if the Court were to find the State in contempt, the State would ask the sanctions be limited to fines that would be stayed pending the State coming back into compliance within 90 days, and order the State to report back to the Court at that time.

That's all I have unless the Court has questions.

THE COURT: Thank you.

Go ahead.

MS. COOPER: Good morning, Your Honor.

I'd like to briefly address two points that the State just made in their closing argument. First of all, under principles of federalism, plaintiffs have not asked this Court to enmesh itself in the minutia of state government. In the relief that we have asked for, we simply asked the defendants to show cause why they're not in contempt and to purge their contempt as quickly as possible to comply with this Court's order.

The other relief we asked for this Court is to have the State issue a plan for compliance that includes elements that are consistent with this Court's order. Ultimately, this Court has very broad remedial authority to enforce its own injunctions. That's why we brought this motion before this Court.

Secondly, as the State's counsel mentioned, the

federal courts do have incremental power to increase contempt actions to force the State to come into compliance and to purge the constitutional violations that are at play. And we know in the state courts that fines have previously been ineffective in reaching compliance. For example, in Director Allen's Exhibit -- I believe it's 2, there is a list of the current people waiting for aid and assist restoration, and there are three people in Washington County still waiting even after that court found the defendants in contempt. That's why we're before this Court.

And this Court's 2002 order is clear and unambiguous. No one is arguing what the defendant's obligations are. Indeed, the Court's reasoning in 2002 was consistent with decades-long jurisdiction that said the nature and duration of someone's confinement has to bear some reasonable relationship to why they're being confined. Aid and assist detainees -- and we know there are approximately 24 waiting -- they're being confined in jails which are designed to punish for the purpose of receiving court-ordered restoration services. So every day they wait, including the proposed next 60 to 90 --

(Cell phone rings.)

THE COURT: Stop, please. I hope that phone has been turned off completely.

Let me ask. You're demonstrating to me that the defendant is out of compliance, which is a given, which the

defendant has accepted as true. So the real question is really, I guess, in two parts as the facts are played out here. One is have they been taking all reasonable steps to be in or regain compliance.

And on our facts, I think that plays out in a couple of ways. One is across the years have they been in substantial compliance, and when out of compliance worked hard to get back into compliance; and two is as they've seen a problem coming in the future, have they taken steps to address it or sort of sat on their hands.

And your argument is really focused on the latter, right? You agree that across the years at least, up until recently, they've been in what we'd call substantial compliance?

MS. COOPER: Yes, Your Honor. To your first point, in terms of 16 years, yes, we do not disagree that the State was in substantial compliance with this Court's order.

What we're concerned about -- and it's not trivial -- is the past eight months.

THE COURT: I made no suggestion it was trivial. It's the argument that I think you're advancing, though, is that they should have seen this coming and did very little about it. That's your point, right?

MS. COOPER: That's correct, Your Honor.

THE COURT: And that does turn in part, at least, or

at least it's important, isn't it, to decide whether that was a foreseeable problem or in some manner at least in part unforeseeable, right?

MS. COOPER: Correct. And if you look at --

THE COURT: You know your opponent's argument, which is that while there's been a continual growth in the aid and assist admissions or orders, the 370 orders, there was a spike, an unexpected spike in 2018.

What do you make of that argument?

MS. COOPER: If you look at the graph itself, which is Exhibit 1 to Director Allen's declaration, you'll see --

THE COURT: I'll look at that, it's just like a lot of statistics, it depends on which graph you ask me to look at. Because when I'm done looking at Exhibit 1, then they're going to ask me to look at Exhibit 2.

MS. COOPER: Correct.

THE COURT: And so I'm asking you to sort out the two for me.

MS. COOPER: If you were to look at this trend over time, the rise in referral rates is indeed predictable. It is an upward trending.

THE COURT: What do you mean? That there will be a rise is predictable?

MS. COOPER: Right.

THE COURT: That's not the question. The question

was was its rate of growth predictable.

First of all, I guess I have two questions about that. One is I don't know why it has to be viewed as ineluctable that if something is rising it will always rise. If housing prices rise, are they going to rise forever? I don't know why the assumption is baked into this that a few years of rise means it will always rise.

But more importantly, the argument you're facing is that yes, we knew there was a rise coming, we predicted it, but we had no way of knowing that it would be as dramatic as it turned out to be in 2018.

What's wrong with that argument?

MS. COOPER: What's wrong with that argument is the defendants in this case are legally responsible to create a system to timely respond to increased demands for services.

And you raise a good point, Your Honor, regarding can we build our way out of this. I think we all agree we're not going to build enough hospital beds to potentially build our way out of this. Where I think we want the State to go is to create a flexible forensic mental health system where things can wax and wane, but who is not held in the balance are individual people waiting in jail with their liberty interests being harmed -- that's the untenable position that the State is in right now -- and that we want them to create a system that can absorb increases in demand and then have a community-based

system that is there to potentially prevent increases in demand.

And what's important about this is that you're not the first court to look at this. Judge Pechman in *Trueblood*, in her order, likewise heard arguments from the State that they could not anticipate spikes in demand, and she ruled, "The department has failed to plan ahead for growth in the demand for competency services which has increased every year for the last decade and has failed to show the leadership and capacity for innovation that is required to address the crisis."

What we're dealing with in Oregon and what Pechman had to deal with in Washington is not unique to these two states. States are obligated under their authority to create the system, and here we don't believe the State has done so.

So what I'd like to do is talk about the all reasonable steps. But did you want to move off the first point about the increase in demand?

THE COURT: I can't tell whether your argument is that -- well, first of all, I can't tell whether your position is that as a factual matter there was or was not a qualitatively different rise in orders in 2018.

MS. COOPER: When I look at the referral list, I see similar numbers in referrals a month or two preceding October. So I don't think it can truly be an unanticipated number, just the number themselves, not mentioning the predictable growth

rate.

And so -- and it would be different, Your Honor, if what we were talking about is one or two people. As Director Allen testified, throughout the 17 years of compliance with this Court's order, we have seen anomalies. We have seen one or two people that can't get in within seven days, but that doesn't justify or explain why there were dozens waiting at the time of filing, and now there are two dozen waiting at the time of filing. That is not, you know, a spike in two or three people that they couldn't anticipate.

THE COURT: So I think I understand your first point. Your second point, I confess, doesn't make sense to me. You can't have a spike of one to two people. The whole point of it being a spike is that it's a lot of people. So if you have a spike, then you'll have more people waiting. That's by definition, right? I mean, if you had one or people out of compliance over the years, that's what happens when there's not a spike.

MS. COOPER: But if you look at the trend line, there are several spikes that increase over time. And so it's not just one anomaly spike that otherwise is a flat line. There are peaks and valleys, and the system should be built to respond to both the peaks and the valleys.

THE COURT: All right. Thank you.

MS. COOPER: And so because the State is not in

substantial compliance with this Court's order, we believe that the true test is in practicability. If you look at both *Stone* and *Hook* and *In re Dual-Deck*, that was the Ninth Circuit standard. If you're not in substantial compliance, all reasonable steps is only available if you are in substantial compliance.

But even if this Court were to consider that defense, what you heard today and in the pleadings does not demonstrate all reasonable steps. We don't disagree that some steps were taken. We don't think that all reasonable steps were taken.

For example, in *Stone*, the defendant spent $30 million on programs to cope with overcrowding, and there they still had eight months of noncompliance, and they were having a difficult time to so respond. And in *Stone*, the trial court -- and affirmed by the Ninth Circuit -- said spending $30 million and eight months of noncompliance is not a defense. You've not complied with this Court's order.

Here we have annual budgets -- and if you look at Exhibit 102 -- that have been cut in half for several years and bienniums by over a million dollars. Here the defendants in the most recent bienniums have cut it to $5 million. That is not a reasonable step to respond to the increase in demand for aid and assist referrals, and had the defendants taken more proactive innovative steps early on, we may not be here.

For example, in our May 9th letter to defendants,

before we filed this litigation, we expressly asked them to expand outpatient community restoration. We firmly believe that that is a reasonable step that is within the power of the defendants.

THE COURT: Certainly within their power, right?

MS. COOPER: Correct.

THE COURT: They have people they are ready to send out of the hospital to the community, and would you -- I guess your point is that they should have litigated those in state court?

MS. COOPER: Potentially. To separate the two, what I mean by community-based restoration is we're actually the leader in that. Last year we passed a bill to allow aid and assist individuals to bypass going to the state hospital and get services in the community.

What I don't know is why the State didn't have competency restoration community sites across the state. Had they taken that step and appropriated those dollars, we may not be here, and that is a reasonable step, both because we have a law that allows for it; two, we have consensus that that's the direction our state is going; and three, if you look at clinical national trends, that's where you see community-based restoration is a best practice because it provides services in the least restrictive environment, reduces harm to people with mental illness, and it's a lot more financially prudent. And

so that's --

THE COURT: Separate from the initial intake into community organizations instead of the state hospital, is your argument that the 24 or 26 people who are ready to be released, creating 26 new beds for admissions, are not released through the fault of the defendant here?

MS. COOPER: No. We think that would be a reasonable step for defendants to take. If they were to release the 24 people they think no longer meet --

THE COURT: Release them where, to whom, when?

MS. COOPER: There are few options. Probably the best clinically is they can contract with private therapeutic providers. For example, residential treatment --

THE COURT: You've heard your opponent argue that they don't view themselves as legally authorized to simply release them without a court order. Do you disagree with that?

MS. COOPER: I do disagree with that. I don't see anything in that statute that indicates they don't have the authority. If anything, the Oregon Health Authority is the state system in charge of the behavioral healthcare system, so residential treatment facilities, those are all contracted and part of the Oregon Health Authority. So one reasonable step would be, hey, let's contract for those treatment beds and get people out of the state hospital, or we can convert those residential treatment facilities into aid and assist beds.

Both are reasonable steps, in our opinion, that could have and should have been taken before we had to bring this action before the Court.

THE COURT: And that can be done, in your view, unilaterally, even though this is occurring in the context of litigation where there are lawyers for each side, possibly prepared to challenge the transition?

MS. COOPER: Your Honor, I'm not sure there's disagreement. If you look at Director Allen's declarations and his slides about where the State plans on going, it includes expansion of residential treatment facilities for this exact purpose. I think the point of contention --

THE COURT: There is disagreement, because he testified that he didn't think he could release these people until he got a state order, and you're saying you think he can.

MS. COOPER: Well, I think part of this is what do you mean by release and to where. We think --

THE COURT: Leaving the state hospital would be one definition.

MS. COOPER: To where? I think where there's disagreement is that they have the authority to potentially release these individuals back to jail or to the streets. I think that's where the State does not want to go -- not to make their argument for them -- and we're saying there are other options than releasing back to the streets. They could release

patients, in particular these 24 that are the quote/unquote drain to help with system capacity, those individuals could go to contracted treatment facilities in the community, because ultimately who we're talking about, whether it's aid and assist individuals or the 24 waiting, both of these populations are committed to the custody of the Oregon Health Authority. They're legally responsible for their care and custody. And that includes looking at least restrictive environments.

And so because they fail to consider that substantial long-term improvement to ensure prompt discharge, that's one of the failings to take a reasonable step. And if anything, what I'm concerned about today, and in the past week, is hearing about the defendants not only not taking all reasonable steps but taking the unreasonable step of considering corrections-based restoration. This has happened in other states with significant challenge and harm to people with mental --

THE COURT: Are you talking about the NWRRC?

MS. COOPER: Yes.

THE COURT: Have you been out there?

MS. COOPER: I have had communications with people who are there and have reviewed their policies.

THE COURT: I don't know quite what to make of this, how this factors in, other than to just say that I've been out there many, many times. It's a close partner of ours in both

pretrial detainees and then rehabilitation for people released from prison. So I'm intimately familiar with how they work. That's an uncomfortable position to be in, since, you know, I just have to say that some of the concerns raised just are factually incorrect about the NWRRC, but I don't want to testify as a witness in this case. But it is a concern for me that what I'm hearing about the NWRRC seems just quite frankly ill-informed about what's going on out there.

MS. COOPER: Well, and I think that's where, if that's the direction the State would like to go --

THE COURT: Well, you know that it is.

MS. COOPER: Given that this Court in 2002 entered several findings of fact that jails and correctional facilities are ill-equipped because they're designed to punish and not treat, I still don't know if the State decides to take that step whether or not it would even comply with this Court's order requiring that restoration services be provided in therapeutic settings.

And Dr. Danna Mauch, who was the court monitor in *Trueblood* --

THE COURT: And you're aware that people in NWRRC can hold down jobs and go shopping and visit family members and things like that, right?

MS. COOPER: Your Honor, my understanding of this facility is it's potentially really great for some people.

THE COURT: I'm just saying if the idea is that it doesn't comply with the order because it's like a jail --

MS. COOPER: What I worry about is what we know about aid and assist individuals, is that their mental acuity is so poor that they're unable to aid and assist in their own defense. That's not the same population as a person who can hold down a job. Their therapeutic needs are inherently different.

And so our clinical expert who has looked at these systems in other states -- and it's in Danna Mauch's declaration in Docket 121, paragraph 24, she explains that they're just designed differently, with a different level of functionality than the population that we're talking about here.

Ultimately, we're worried because this may be a cheaper but less effective solution than providing therapeutic hospital level of care. And we know that there are options in this state. We know there are residential treatment facilities. In particular, there are 33 that are in the State's plan.

We urge this Court to consider, when looking at ordering relief for these individuals, that you also consider the Americans with Disability Act and *Olmstead*, that we look to provide services in the least restrictive setting not the most restrictive.

So that's part of our concern with these facilities, but like you, we're open to learning more, to see if this can meet the therapeutic needs of the class. As designed now, we don't believe it does.

THE COURT: Thank you.

MS. COOPER: So ultimately we're concerned that these steps that could have been taken have not been taken, and we understand that the State has a constitutional obligation as a part of the government of the state of Oregon to protect individuals that are found so ill they are unable to aid and assist. The law embraces the legal concept of the caretaker of people in detention is the person responsible for their welfare, even if they're not the direct person responsible for that person coming into their care.

For example, in *Stone*, when a jail is overcrowded, we embrace the concept that the local sheriff or the jail commander is the person to be sued, even when that person has little to no say in who gets charged and what their sentence is. No doubt there are choices made here in Oregon, made from district attorneys, judges, law enforcement that affect a number of people committed to the state hospital under aid and assist, but the longstanding concept of custodianship means the defendants in this present case cannot point the fingers at others to avoid contempt in this matter, nor would any verdict of contempt be a condemnation of individual defendants as staff

people indifferent to the needs of detainees. Ultimately holding the State --

THE COURT: I guess I'd like to test that proposition just a little. I mean, I'm not saying this is the case here at all, but it is a system-wide problem that starts with charging decisions that can be made differently, maybe frequently ought to be made differently, or arrest decisions. It starts earlier than that with the lack of treatment generally available that lands people in law enforcement's orbit, and on down the line.

And so you're asking me to really take a pressure point -- in some ways it reminds me of what's happened with the local jails, which have become really -- or have in the past, I guess I'd say, been the dumping grounds for everyone else's failures with people involved in the law enforcement system with mental health issues.

But why is that the right answer to say, well, you know, we played musical chairs and you lost, even though everyone else is the reason that this problem exists, so we're going to use the jail or the state hospital as the place where we'll impose an injunction that's really designed, if I read your briefing correctly, to solve the whole problem by putting pressure on one entity of the state.

Why is that the right answer?

MS. COOPER: If you look at the Court's reasonings in *Stone*, *Hook*, *Trueblood*, or even this Court in 2002, it's a

recognition that there are certain state actors -- here the Oregon Health Authority and the state hospital -- that have an authority in that trigger place, and that they can and should take reasonable steps to comply with the Court's order and they have failed to do so.

And to give you an example of this, you're right about the charging decisions. Senate Bill 24 was just introduced this past legislative session. Why wasn't it introduced five, ten years ago? This is something that the State can do. The problem here is that it's too late, and we have two dozen people being harmed every day that they wait in jail.

And so they're responsible, and because they're responsible in their official capacity, we've embraced this legal concept that they're legally obligated to create a forensic mental health system that can respond to meet the needs of people that entered it. And we lobbied efforts to reduce the referral rates, and if anything, what we're doing in this proceeding is pushing that, saying, yes, excellent, but let's expand community restoration everywhere, let's expand diversion everywhere, and it's great that it's happening today, but we want it to be yesterday.

THE COURT: Right. I agree with that. My question isn't is it laudable to expand those efforts. My question is is the right tool to expand those efforts contempt?

MS. COOPER: Yes, Your Honor, specifically because what we've asked for in our remedy for contempt here is a plan for compliance.

THE COURT: That plan contains -- that plan involves the actions of how many actors other than the defendant here?

MS. COOPER: We would only propose that it would be the defendants in this matter, because again, the Oregon Health Authority is the entity responsible for the statewide community mental health system. They're in charge.

THE COURT: Your plan for compliance to succeed would depend upon changed behavior by several entities outside the defendant, right?

MS. COOPER: We would not propose that at this time, no. We think what's before this Court and the party this Court has jurisdiction over is the Oregon Health Authority and the Oregon State Hospital, and so we think it's those two entities that should come up with a plan for compliance.

THE COURT: Well, for example, if part of your plan is that there be a wide-spread set of community care organizations either at the front end or the back end, either to avoid referral to the state hospital or to go there after a short time in the state hospital, I mean, that system has to exist. It has to be funded and exist, right, and be ready to handle all that?

MS. COOPER: One way to look at it, Your Honor, is if

you look at Director Allen's plan, it includes expanding residential treatment facilities. It includes crisis services, it includes diversion.

THE COURT: Well, his plan involves that there be expanded residential treatment facilities, but his plan doesn't involve the state hospital going out and building them. That's got to be somebody else, right?

MS. COOPER: Potentially. He testified today that there's capacity at Oregon State Hospital in Junction City. That's within the care and custody of the defendants.

But the thing that's important to note here --

THE COURT: So you're agreeable to Junction City being used as a place for increased capacity for community care?

MS. COOPER: Not for community, Your Honor, but for compliance with this Court's injunction, yes. Do we think it's the best answer? No. Is it a bitter pill to swallow potentially? Yes. Because what's in front of this Court is a seven-day standard, and so I don't think we can sit up here and be picky and choosy about where people go. We simply want to say that in jail people are being harmed. We know that every single day someone is in jail, they're harmed. So where they go according to this Court's 2002 order is a therapeutic location designated by the defendants to provide competency restoration services.

And it's that harm in that seven days that we want -- we want them to purge their contempt as quickly as possible by either releasing or admitting the current wait list as soon as practicable but no longer than seven days, and then that plan for compliance is how they're going to maintain that, because again, as Washington County Sheriff Garrett testified, what we worry about is mentally ill inmates decompensating to the point where they're smearing their own feces, they're engaging in yelling and mumbling, and they get to the point where they withdraw, where they don't eat, speak, or respond.

Similarly, the National Alliance on Mental Illness and the Tillamook Family Counseling Center both entered declarations talking about how they see people harmed every day by these delays.

THE COURT: I couldn't agree more. I don't want to have you mistake my questioning here. The problem is a deeply serious one, and I agree fully with the prior order as the embodiment of the substantive due process rights involved here, and I take very seriously what happens to people that spend too long on an aid and assist regime in a county jail where they can't be helped.

So I've read those declarations. I agree that it's a very serious problem. My concern isn't whether we ought to cure the contempt -- excuse me, whether or not to bring into compliance the defendant, my only real concern for today's

purposes is whether the right answer to make that happen is contempt or something else.

MS. COOPER: Your Honor, it's up to this Court to determine the remedial measures to purge this constitutional violation. What we ask for, in addition to admitting or releasing patients or ensuring that plan for compliance, is potentially to consider an expert or a court monitor, if this Court would find it useful. There have been experts in other settings that are neutral that have helped other states get into compliance, namely, Dr. Danna Mauch. She has worked with several states' mental health systems. We also know through the Oregon Performance Plan that defendants have already worked with Pam Hyde. And so there are people out there. The State even just hired a new mental health director. There are people out there that this Court can enlist in helping the State get and maintain compliance, and that's an option this Court may wish to consider, especially given that we've got some questions about the Northwest Reentry Center and where -- what is the best remedy to this violation I think is a question we all have.

This matter today is simply that there is a violation. We think defendants should be held in contempt and should be ordered to purge their contempt as soon as practicable and no later than seven days.

THE COURT: All right. Thank you very much.

MS. COOPER: Thank you.

THE COURT: Your reply?

MR. MERRITHEW: May I, Your Honor?

THE COURT: Go ahead.

Give me just one moment.

(There is a pause in the proceedings.)

THE COURT: Go ahead, sir.

MR. MERRITHEW: Thank you.

Your Honor, I'd briefly respond to the Court's question about what to make of this chart that has been submitted as Exhibit 1 to Director Allen's declaration. I would submit to the Court that not only is the steady rise, the mean rise in referrals to the state hospital steady and predictable, the spikes where the monthly referrals are higher than the mean are equally predictable.

If you were to look at this chart, Exhibit 1, and try to identify where the defendants say this unpredictable rise occurred, my guess is that you would not be able to just pinpoint it without looking at the dates, because throughout, since 2012, over the last almost seven years, there have always been increases month to month, and those increases over the mean have not increased significantly in the last six years. The State's obligation throughout was to be able to plan for those spikes.

I would also submit that the fact that there is still

a wait list today demonstrates the fact that this is not due to a momentary spike. It is because all along throughout this process, if you look at the numbers that they think were good -- for example, from January of 2018 through October of 2018 -- what in fact was helping was they were treading water. They were at an average wait time of six and a half days usually for a person to be transported from the jail to the state hospital. The reason there was these constant problems with court orders and transportation is because they were just barely complying with the Court's order, so any increase was going to cause what happened. That was predictable.

I am here representing Metropolitan Public Defender's Office, and we're not here to solve the whole problem of the State's delivery of behavioral health. We are here because our attorneys have to bear witness to the suffering of people who are in jails. That suffering is a direct result of a violation of the Constitution.

When you look at *Stone*, at *Hook*, and the other cases in the Ninth Circuit that are the most applicable to our situation, those are prison crowding cases or jail crowding cases. The courts in those cases took drastic action. They stepped in and forced the State to release people who had been convicted of crimes and sentenced before their sentences were complete. The federal courts in this country forced the State to release people in violation of a state court order. They

did that because of a risk that people within those jails and prisons may suffer a constitutional injury because of the crowding.

What that means is that they took those drastic actions, when probably 19 out of 20 prisoners would enter those jails or enter those prisons and come out without having their constitutional rights violated. They took those drastic actions for the one in 20 who might not have his medical needs met or his mental health needs met or might be assaulted because of crowding.

Here what we have is a list. The names are redacted from the list, but the Court has those people nonetheless. There are 24 people who are currently suffering a substantial injury. Every minute this hearing goes on, they're in a jail cell, in violation of their constitutional rights.

The Court in *Stone* said -- they adopted a statement from a district court opinion that when federal constitutional rights have been violated, principles of restraint, including comity, separation of powers, and pragmatic caution result.

This Court's power in hearing the constitutional violation could not be higher. Anything that needs to be done in order to fix the problem, this Court is authorized to do it. What we are asking the Court to do is to order them to either release or transfer those 24 individuals immediately who have been held in violation of their constitutional rights.

THE COURT: Released where?

MR. MERRITHEW: The streets if necessary. Currently they're in most likely an isolation cell in a local jail. They're receiving no mental health treatment. They are suffering. Being released, while not a great result, is the necessary result to end their suffering, to end the constitutional injury.

THE COURT: You're in a difficult position here, I guess. One is that you've confessed that you're not really trying to solve the holistic problem but just the immediate problem, and it's always difficult because to the degree that you feel that you have clients being harmed, those are clients who don't have a real attorney-client relationship with you, in the sense of they being able to tell you what they want. It would be one thing if you could tell me that your clients wanted to be released, but you don't really know that, do you?

MR. MERRITHEW: What we know is do they have the capacity to direct at the level that we need them to direct in order to direct their defense? No.

THE COURT: And make critical decisions and to give you the information you need to advise them. They don't have that capacity, right?

MR. MERRITHEW: They do not. They do not, Your Honor. However --

THE COURT: I'm just concerned you're suggesting a

remedy without knowing what your clients themselves want, let alone what would be best for the system.

MR. MERRITHEW: The clients themselves, if you were to witness the state that they are in, I don't think it's a reasonable alternative that any person in that state would want it to continue. To see somebody in what the jails call a suicide smock in a cell that is lit 24 hours a day, where they maybe get out of it an hour a day, if they have the capacity to get to the door when it's unlocked, this is not a state that any person if they were rational would choose to be in, and this -- it is a difficult position that we're in, in that we cannot effectively speak for our clients because the principal-agency relationship doesn't exist when somebody is so incompetent. So we're not here representing -- those individuals are not plaintiffs in this suit.

THE COURT: Right. You are.

MR. MERRITHEW: We are, the Public Defender's Office is.

THE COURT: Certainly you have something to add, I appreciate that, because you have made the visits and are aware of the physical conditions, although I should say that I myself have been in this system since 1988, so it's -- I'm not unfamiliar with what you describe.

MR. MERRITHEW: Your Honor, if the Court is troubled at all by that portion of our reasoning, you need look no

further than the findings made by Judge Panner. Judge Panner recognized this particular problem, the suffering that was going on for folks that were held in jail, awaiting transport, and he came up with a simple solution, and by everybody's agreement, that simple solution worked for 16 years.

THE COURT: He did come up with a simple solution. What he didn't say is if that doesn't work, put people out on the streets.

MR. MERRITHEW: I think it's inherent in the order, because what he said is make it work. One way or the other, make it work. And by putting people on the streets, if that's what's necessary, then the constitutional injury ends. When they're released, the constitutional injury ends, and that's -- I would submit that that's this Court's highest obligation, is to end that injury. There are smart and capable people now working for the State who are working very hard to come up with long-term solutions to the problem, and that's great, but our concern is what happens in the interim. Their solution --

THE COURT: Can I ask you a different question now. I understand that argument and I take it seriously, so I'm not trying to cut you off, but I am curious what you think my authority in this case allows me to do with regard to a small subset but an important group. That is the group that the state hospital has determined are ready to be transferred to community treatment but is holding on to because they view

themselves as requiring a state court order before they can do so. Are you familiar with that statutory framework?

MR. MERRITHEW: Yes.

THE COURT: What's your view?

MR. MERRITHEW: My view is that the statutory framework is not explicit, and I would have hoped that the state hospital would have been more robust. If you look -- one of the reasons that we submitted to the Court --

THE COURT: I'm not sure I know what you mean. Robust in doing what?

MR. MERRITHEW: So the (6)(b) notice is in evidence in front of the Court, it's an exhibit to the stipulations that were filed yesterday evening. When one reads that notice, it doesn't give the impression that the state hospital is in a very big hurry to get these folks out of the hospital. In fact, what it says is we will hold this person pending any further court action. So that's where it starts.

THE COURT: Well, I mean, if that's what they think the law requires, then they can't say much else, right? My first question is do you think that they need a state court order to release people to community treatment?

MR. MERRITHEW: The statute is ambiguous, and in order to -- if that's what's necessary, then no, they don't. If they feel like they do, this Court has authority to override any state law that is causing a constitutional violation. So

if that authority is lacking within the statute, this Court is able to give them that authority in its orders.

THE COURT: All right.

MR. MERRITHEW: But the bigger question for us is the people who are at the front rather than at the back end, because at least the people at the back end are in a hospital in a therapeutic setting. Those folks are not having the constitutional rights violated right now by continuing to be in --

THE COURT: Well, it's just, as I say, if you're looking at it holistically, creating 26 openings at the back end gives you 26 new beds at the front end.

MR. MERRITHEW: That's absolutely correct. And --

THE COURT: And if, as is suggested, that of the 40-some people currently awaiting placement, there's something like 20-some of them who are over seven days, and I send 26 people out of the state hospital into community corrections, then we've accomplished something by creating the number of openings we need immediately.

MR. MERRITHEW: I would agree with that, Your Honor. Our criticism of the Health Authority and the state hospital with regard to its treatment of those (6)(b) notices is just that they send a letter, which is not very strongly worded, and that's the end of the effort.

THE COURT: Let me ask you another statutory

question. It's been suggested that they can just unilaterally do this. So you might represent someone in a case like this. Would you view that as depriving you of a required opportunity to litigate the (6)(b) letter if they just unilaterally placed someone in community treatment out of the hospital, or is that something that you view them as having the unilateral authority to do?

MR. MERRITHEW: I don't think the statute creates any options. I don't know what authority any court, any state court has read that statute and concluded that they could override the state hospital's --

THE COURT: I'm asking because the suggestion from the witness was that occasionally these are litigated, opposed by counsel in those cases.

MR. MERRITHEW: I have not seen a case where defense counsel opposed the release of one of the (6)(b) patients to community restoration.

THE COURT: That seems unlikely, right?

MR. MERRITHEW: It sure does. I took his testimony to mean the district attorneys in those cases.

THE COURT: And have you seen that?

MR. MERRITHEW: I have not. Our office did go to great lengths when we received one of these notices to get a person released, including filing a writ of mandamus in the Oregon Supreme Court, and there was no action taken by the

Supreme Court.

THE COURT: I'm not finding the chart. Are there people with (6)(b) notices that have been sitting there for months, right?

MR. MERRITHEW: The longest wait is now almost seven months, I believe.

THE COURT: Thank you very much.

MR. MERRITHEW: Thank you.

MS. SCOTT: Just one final point with respect to releasing the (6)(b) patients. The statute itself requires the State to keep the patients in the hospital until there is a court order, subsection (6)(b).

THE COURT: So you agree that if I found that statutory requirement to be creating a constitutional violation, that I could then effectively have a federal court order in substitution, ordering their release, ordering the release of people that you -- your client has determined are ready to be released to community treatment?

MS. SCOTT: That leads me to the next point that I was going to make.

THE COURT: Does that mean the answer to my question is yes?

MS. SCOTT: Not yet, Your Honor. In the *Stone* case, for example, at issue was the federal court's power to authorize the sheriff to order early releases, contrary to

sentences issued by state court judges, and the Ninth Circuit in that case said that's a last resort. First you need to start with fines. And that's on -- at the very end of the *Stone v. City and County of San Francisco* case.

THE COURT: So I guess I'm curious about that position for you, though. You'd like to see these people released. You just want a court order?

MS. SCOTT: Correct.

THE COURT: If I gave you a court order, where's the beef?

MS. SCOTT: The principle -- well, the *Younger* abstention doctrine would apply. It's very rare where federal courts are going to interfere with state court orders. The state court judges have considered the facts and circumstances of each of these particular patients, and that process should be allowed to play out. The State is evaluating on the in-progress options --

THE COURT: Can I ask what it is you expect a state court judge to do when they receive one of these letters by way of evaluation?

MS. SCOTT: They are familiar with the individual defendant's case, and if they're not acting on a (6)(b) letter, the State is taking steps to get that court's attention, and that is among the items that Director Allen --

THE COURT: Well, that's what I'm asking. Your view

is that a state court judge receives this and has the discretion whether to issue the order or not. It could decline to issue the order and decide that the person is not ready for community treatment, right?

MS. SCOTT: That's correct. In some cases the state court judge does look at it and decide that they don't agree with the state hospital. And that's why Senate Bill 24 is being proposed right now, which would be to give the hospital more authority to enforce its (6)(b) letters. That's one of the reasonable steps that the State is taking. So we're not there yet where we need a federal court order.

THE COURT: To enforce them meaning to get the state court to issue an order or to do it without an order?

MS. SCOTT: Correct.

THE COURT: I gave you two choices. They can't both be correct. So which do you mean?

MS. SCOTT: Senate Bill 24 right now is proposing to make the language in the (6)(b) subsection more enforceable by the hospital in the event that the state court does not act on a (6)(b) notice.

THE COURT: I see. Thank you.

MS. SCOTT: So, in closing, the sanctions for contempt, the case law is clear, need to be narrowly tailored, and they should start with fines, especially in light of the overall plan that the State has presented today.

THE COURT: Thank you very much.

I regret that I have to take this under advisement and pick up some other matters that have been waiting on, so I'll get back to you as soon as I can.

We'll be in recess.

THE CLERK: This court is in recess.

(Proceedings concluded at 11:33 a.m.)

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I certify, by signing below, that the foregoing is a correct transcript of the record of proceedings in the above-entitled cause. A transcript without an original signature or conformed signature is not certified.

/s/Bonita J. Shumway *June 17, 2019*

BONITA J. SHUMWAY, CSR, RMR, CRR DATE
Official Court Reporter

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